Ear Nose & Throat
OF SPRINGFIELD
Quality care, close to home.

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Certified: American Board of Otolaryngology
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Patient Information Chart #

Date | Pharmacy | Race* | Ethnicity *

Patient Name | Birthdate | Age | Sex

Address | Preferred Language

City | State | Zip | Marital Status

Home Phone | Cell Phone | Work Phone

SSN # | Employer | Occupation

Family Doctor | Referring Doctor

Emergency Contact | Phone Number

Responsible Party Information (If other than Patient) -- Person signing this form must be 18 or older

Name | Billing Name

Relation to Patient | Billing Address

City | State | Zip | Date of Birth

SSN # | Home Phone | Work Phone

Insured SSN# (if other than responsible party)

Primary Ins. | Policy Holder

Ins. Address | Insured Address

Policy ID # | Relation to Patient

Group # | Copay $ | Date of Birth

Secondary Ins | Policy Holder

Ins. Address | Insured Address

Policy ID # | Relation to Patient

Group # | Copay $ | Date of Birth

*Note: We are now required by Government to ask for Race and Ethnicity, but providing it remains your decision.

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What is your email address?

**Providing your email address will enable us to send you an invite to join our new patient portal.*

Who is authorized to share your medical information if requested?

By your signature, you are authorizing ENT of Springfield to serve on your behalf as representative to your insurance carrier. This includes, but is not limited to, the release of medical information and the request that payment be made directly to ENT for services rendered. It is also understood that you abide by ENT's Financial Policy, as printed on the next page. You may request a copy for your records. You are also indicating that you have been furnished with a copy of the Health Information Privacy Rights.

Signature of Responsible Party

Date

Annual update of Responsible Party

Date

Annual update of Responsible Party

Date